Working Group on drug-related deaths

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SCOTTISH ADVISORY COMMITTEE ON DRUG MISUSE

Working Group on Drug Related Deaths

Report and Recommendations

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Scottish Advisory Committee on Drugs Misuse (SACDM)

Short-Life Working Group on Drug Related Deaths

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1. Background

Introduction

Following the publication of the Association of Drug Action Teams report on Drug Related Deaths in January 2005, and in advance of the publication of the National Investigation into Drug Related Deaths Report, in May 2005 the Scottish Executive tasked a short-life working group of the Scottish Advisory Committee on Drug Misuse (SACDM) to consider both reports and to develop recommendations regarding the framing of a policy response that would support a future reduction in drug related deaths in Scotland.

A full list of the Membership of the SACDM Working Group is given in Appendix A.

The remit of the SACDM Working Group was to:

- Compile a set of practical recommendations based on the final report of the National Investigation into Drug Related Deaths in 2003, by 1 July 2005;
- Take into account local solutions and ideas when determining the recommendations based on the final report of the Association of Drug Action Teams Drug Related Deaths Working Group;
- Consider best practice from other regions;
- Explore the future role of GPs in identifying 'at risk' cases; and
- By 15 July 2005 produce a draft plan with a view to the Scottish Executive taking action to reduce drug related deaths in Scotland.

The SACDM Working Group met for the first time on 25 April 2005 to discuss key points raised in both reports, identify similarities and points of difference that would allow the development of recommendations with key action points in the most important areas that the reports had identified. It then met on 4 further occasions prior to publication of the report on 8 August 2005.

The National Investigation

In 2003 the General Register Office for Scotland (GROS) reported the country's highest ever annual number of drug related deaths, 382 deaths during 2002 (GROS 2003). The Deputy Minister for Justice, Mr Hugh Henry, subsequently commissioned a national investigation into all drug related deaths in Scotland for the year 2003.

The aims of the National Investigation were:

- To collect and analyse information relating to the clinical and social circumstances surrounding all drug related deaths in Scotland for the period January to December 2003;

- To identify patterns in social and clinical circumstances surrounding the deaths, and associations between them; and

- To make recommendations for policy and practice that may lead to a future reduction in drug related deaths.

Chapter 7 of the National Investigation Report (see Appendix B) reviewed the findings from each individual chapter and drew together a final set of conclusions along with associated implications for service commissioners and providers. These were drawn from the 'key points' sections of each chapter.

The Association of Drug Action Teams Drug Related Deaths Working Group

The remit of the DAT Working Group was to:

- Support the sharing of information across local Drug and Alcohol Action Teams (DAATs) on strategies to prevent drug related deaths;

- Identify relevant local initiatives currently being advanced by DAATs and to explore common themes and issues;

- Make recommendations on future information sharing arrangements across DAATs; and

- Make recommendations on key initiatives that DAATs and other partner bodies might wish to consider advancing.

The importance of co-ordinated action on reducing drug related deaths is a primary concern for all DAATs in Scotland. DAATs were tasked (through national targets) to reverse the upward trend in

drug related deaths and to ensure a reduction of the total number of deaths by at least 25% by 2005.

In order to support continued action and thinking on the best mechanisms to reduce drug related deaths, a short-life working group was convened as a priority area out of the DAT Associations' 2003-2004 annual work plan.

The DAT Working Group Report developed two sets of recommendations (See Appendix C). These cover Action Team and Local Services, and National Strategy, Co-ordination and Communications.

Developments since publication of DAT Working Group Report

It should be noted that two of the recommendations from the DAT Working Group Report have now been actioned:

- Article 4 of The Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005 (SI 2005 No 1507), added Naloxone to the list of medicines, in Article 7 of the Prescription Only Medicines (POM) Order, that may be administered parentally by any person in an emergency. This change means that Naloxone can now be administered by 'any person' in an emergency to save life.

- The Scottish Executive in association with the Scottish Drugs Forum (SDF) announced that a multidisciplinary conference 'Taking Action on Scotland's Drug Related Deaths' will take place in Glasgow on 8th August 2005.

SACDM Short-Life Working Group

In drawing together a common set of recommendations and action points for the Scottish Executive the SACDM Working Group focussed mainly on common themes and issues from both of the above reports. However, it nevertheless endeavoured to keep sight of some individual, but none the less important issues. Where possible, we have cross-referenced each recommendation and set of action points, to comments from the two above reports.

It was possible to draw some key messages from both reports.

These are that:

- There is a lack of uniformity across services in how drug related deaths are reported. It is difficult to identify the population and any reported changes in trends may not be valid unless the population is known.

- The National Investigation found that it was difficult to identify and extract good quality information from patients' clinical records. At times the information contained in patients' notes was of poor quality or there was poor recording of data.

- In many instances 'case files' relating to victims were held by generic services, which sometimes did not have effective methods for dealing with them or of recognising the importance of information that was contained within them.

- Some of the assessments and treatments available from specialist services were not evidence based and offered a limited range of options.

- The quality of prescribing varied across the country as did access to supervised consumption places in pharmacies and access to a number of other essential services e.g. medical assessment (both in general practice and in specialist services).

- Not all services that deal with drug users delivered comprehensive harm reduction messages.

- Both reports highlighted the need for increased training and awareness raising for everyone including drug service personnel, health professionals, ambulance and police service personnel, prison officers and staff, drug users, their peers, friends, families and carers.

- Both reports highlight the urgent need for joined up working, and the importance of exchanging and sharing information between agencies and services whilst taking account of issues relating to confidentiality.

2. Recommendations and Action Points

These are drawn from both the conclusions, implications and key findings of National Investigation into Drug Related Deaths in Scotland and the recommendations of the DAT Working Group.

In developing the recommendations and action points below, the SACDM Working Group recognised that these will only be achieved if the required support is available to fund them and take them forward.

The SACDM Working Group suggests that the advice of service users is sought before taking forward and implementing these recommendations.

2.1 Improving responses to overdoses

Raising awareness

The DAT Working Group identified injection and polydrug misuse as key factors in drug related deaths. The National Investigation found that the detection of benzodiazepines was the most common toxicological finding. Few cases were positive for psychostimulants, in particular cocaine. In Scotland, the predominant drugs found at the time of death were heroin/morphine, benzodiazepines and alcohol.

Training for carers, friends and users

The National Investigation found that there were missed opportunities to intervene and save the lives of many of the people who died. Less than half of those present at the incident had tried Cardio-Pulmonary Resuscitation (CPR) and in most cases they had died by the time the ambulance arrived.

In those cases where a witness was present the most frequent intervention attempted was CPR, followed by various inappropriate combinations of slapping, using cold water or showering. Worryingly, no intervention was attempted by those witnesses present in nearly 40% of cases. Working group members welcomed the change to the Medicines Act that makes it possible for 'any person' to administer Naloxone in an emergency to save life. However, the Investigation Team recommends that those in a position to administer Naloxone should receive appropriate training and that steps are in place to ensure that increased availability does not lead to a false sense of security among those administering it or, indeed, among drug users themselves.

The SACDM Working Group believes that there is an urgent need to raise the awareness of drug users, their families, friends, carers, and of generic staff most likely to come into contact with them, on the dangers of mixing drugs, and in particular the dangers associated with mixing opiates, benzodiazepines and alcohol.

Recommendation 1

The Scottish Executive and DAATs should consider methods to raise the level of resuscitation skills among drug users, family members, friends, and social networks. It is recommended that the provision of information and training for families and friends of drug users and drug users themselves is further developed across Scotland.

Suggested Points for Action

- Scottish Executive to commission the development of a range of materials aimed at raising awareness among target groups of the causes of drug related death (to include leaflets, posters and computer based information), which can be customised for local use.

- The Scottish Drugs Forum to further develop and roll out the training of drug users, their families and friends to take appropriate action in response to a suspected drug overdose.

- DAATs and their NHS Board, Social Work and voluntary sector partners to make information about the dangers of mixing drugs and alcohol available to drug users from a range of outlets such as support groups, services, general practitioners (GPs) and community pharmacies.

- DAATs to ensure that the specific targeting of the non-injecting drug using population is undertaken in their areas.

- Drug services to provide training on basic resuscitation and life support techniques to drug misusers, their families and friends as part of their core service provision.

Scottish Police Service

The Association of Chief Police Officers in Scotland (ACPOS) is the body that decides the national strategies and policies, which give direction to the work of the police service in Scotland, including the Scottish forces and the Scottish Drug Enforcement Agency (SDEA).

The National Investigation found that the police were in attendance at 90% of the scenes of the overdose following a call, in most cases

where it was known, from either the ambulance service (18%), or a friend or acquaintance (16%). At the scene the police undertook no activity in 87% of cases, in 5% of cases they were called to obtain access to the overdosed person e.g. force entry through a locked door, and in 10 cases police performed CPR.

Perceived Barriers to Contacting Emergency Services

The National Investigation report examined the experience of overdose survivors, and found that fear of the police, and, in particular, fear of being arrested and blamed if the person died, was identified as the greatest barrier. This concern often resulted in Injecting Drug Users (IDUs) either not reporting the overdose or not staying to help the overdose victim. One hostel dweller claimed 'a lot of people die because others don't want to go downstairs [in the hostel] and say "he's overdosed" '.

The National Investigation also found that in nearly half (48%) of cases, others were present in the vicinity of the overdose event. The period of time that had elapsed between overdose and death for most cases investigated was several hours or more (50%), or within an hour (14%). At some (unrecorded) point in time after the overdose became known to others, an ambulance was eventually called to the scene in 82% of cases. In 81% of these cases, the person was already dead by the time the ambulance arrived.

Since October 2003, a Memorandum of Understanding (MOU) between ACPOS and the Scottish Ambulance Service has been in place. This seeks to ensure that the police service is contacted by the ambulance service when a call is received regarding an overdose of controlled drugs.

Recommendation 2

ACPOS and the Scottish Executive should jointly explore ways in which contact with the police can be used as an opportunity to intervene with vulnerable individuals in order to prevent future drug related deaths. In particular, the MOU between ACPOS and the Scottish Ambulance Service should be reviewed in order to ensure that, in the event of an overdose, help is available as quickly as possible. The police attending the scene of an overdose should ensure that preservation of life should take precedence.

Suggested Points for Action

- The memorandum of understanding between ACPOS and the Scottish Ambulance Service to be reviewed and any changes

to be clearly communicated in order to ensure, that in the event of an overdose, help is available as quickly as possible.

- Contact to be made with Greater Manchester Police to obtain information on scheme in place in the Greater Manchester area.

Need for further research

In 2000, the SACDM Research sub-group produced a report that looked at research that could inform practice more directly. This report highlighted in particular that research should:

- Provide practical guidance and information for practitioners.

- Give priority to qualitative research that improves understanding.

Members of the DAT Working Group considered that on a number of occasions the impact of the current ACPOS and Scottish Ambulance Service protocol on responding to drug-related overdoses, or suspected overdoses led to delays in an ambulance being called. DAT Working Group members noted that a legal dilemma might exist in some instances in that the Lord Advocate's guidelines state that all deaths are to be treated as a potential culpable homicide and the Scottish police are duty-bound to investigate.

As highlighted above, a joint protocol between ACPOS and the Scottish Ambulance Service currently requires that the police are notified and attend the scene of an overdose. The DAT Working Group suggested that consideration should be given as to whether automatic involvement of the police might, in some instances, delay witnesses calling for an ambulance. During the course of its deliberations, the SACDM Working Group was made aware of some preliminary work being undertaken with focus groups by the SDF in an attempt to investigate this matter.

Recommendation 3

The Scottish Executive should commission applied research to explore drug user perceptions, and those of their friends/family, with a view to understanding how delays in contacting the emergency services can be reduced.

Suggested Points for Action

- The Scottish Executive to commission in-depth applied research to identify whether the existing MOU between the

police and ambulance service is in fact a barrier to witnesses calling emergency services to attend suspected drug overdoses.

- Research to be undertaken to identify the perceptions of drug users and those of their friends and family to automatic attendance by police at suspected drug overdoses, building on preliminary investigation undertaken by SDF with focus groups.
- The findings from this research to build on the preliminary investigation undertaken by SDF with focus groups and used to address impact of perceptions and improve emergency service responses to drug related deaths.
- Proposed Local Critical Incident Sub Groups to monitor impact of ACPOS/Scottish Ambulance Service Memorandum on time taken by witnesses to call ambulances to drug overdose or suspected overdose.

2.2 Improving the quality of existing responses

The National Investigation found those in contact with specialist services were mainly accessing medical treatment (such as the prescription of methadone) or Social Work interventions. However, only 17% of those known to services were in receipt of a substitute prescription service at the time of death.

The investigators found that prescribed medical treatments were not always delivered in keeping with national guidance and accepted quality standards. Particular concerns related to methadone prescribing and dispensing standards, the prescribing of long-term opiate analgesics and benzodiazepines, and the illicit availability of prescribed medications. There was also evidence of little contact with support or counselling for those in receipt of substitute prescribing.

It is essential that the Scottish Executive (through DAATs, NHS Boards and professional bodies/Royal Colleges) is in a position to ensure that the delivery of all medical treatments for substance misuse or prescription of drugs that have abuse potential, is evidence based and practised to the highest standards, in line with national guidance. All substitute prescribing must be subject to audit and clinical governance processes. Progress could be reported through the DAAT Corporate Action Plans (CAPs) or the NHS accountability process.

Ensuring evidence based practice

There is a strong evidence base which supports the view that there is a relationship between dose and outcome in methadone prescribing, with higher doses being associated with better clinical and harm reduction outcomes. Good practice is for methadone prescribing to be delivered alongside various psychosocial or counselling interventions; an approach which the researchers suggest has also been associated with better outcomes. One area of concern to the SACDM Working Group was the apparently low level of prescribing of high dose buprenorphine (Subutex®) in Scotland compared to England and Wales.

Quality and quantity of prescribing in Primary Care

The SACDM Working Group was concerned to learn of anecdotal reports of an apparent reduction of GPs' involvement in Shared Care Schemes following the introduction in April 2004 of the new NHS General Medical Service Contract (nGMS). In theory nGMS introduces an incentive scheme for practices to provide care to drug misusers. It is for NHS Boards, in discussion and negotiation with local primary care providers, to determine the service that best meets local needs.

Both the nGMS and the proposed new community pharmacy contract (nGPS) have the potential to add significant resources to the treatment of substance misuse. These give NHS Boards and their partners an opportunity to create a contractual framework that is geared towards improving the quality of care delivered to substance misusers in Scotland.

Recommendation 4

NHS Boards and their primary care management components should be encouraged to employ the nGMS and nGPS frameworks to increase access to high quality, evidence based treatment programmes for substance misusers.

Suggested Points for Action

- The new GP contractual process to be maximised as a means to promote change.

- The new Pharmacy contract should be seen as an opportunity to increase the number of supervised consumption places available in community pharmacies.

New and Innovative Treatments

All substance misusers in Scotland must have rapid access to the full range of treatment options appropriate to meet their needs. New or more innovative treatments such as high dose buprenorphine or diamorphine prescribing may allow some who cannot successfully use methadone treatment programmes, to remove themselves from the dangers of illicit drug use. However, the introduction of such programmes must be co-ordinated to maximise impact and care must be taken to ensure the capacity of the methadone programme is not threatened by diversion of resources.

There is an increasing body of evidence on what can impact on reducing drug related harm including drug related deaths. It is crucially important that Scotland takes note of this evidence and does not take a blinkered view. For instance, the use of other opiate substitute medications, such as Subutex®, should be actively explored. There is evidence from France and Australia to suggest that the introduction of Subutex® has made a significant contribution to the reduction of drug related deaths.

The DAT Working Group considered that, whilst limitation on time meant that they had been unable to form any clear views, there were reports from elsewhere of new initiatives that might help form part of a Scottish strategy for preventing drug related deaths. They suggested that these could include the use of safer injecting rooms targeted at high-risk homeless individuals, heroin prescribing and the provision of greater outreach services to older and more vulnerable drug users. It is interesting to note that the World Health Organisation (WHO) has recently added both methadone and buprenorphine to its Essential Drugs List.

Recommendation 5

The Scottish Executive should develop and fund a co-ordinated process of introduction and evaluation of new or more innovative treatments across Scotland, with the aim of ensuring that substance misusers in all DAAT areas have access to a range of evidence based treatments.

Suggested Points for Action

- The Scottish Executive to confirm evidence that the increasing use of high dose Buprenorphine in France and elsewhere is associated with a substantial decline in drug related deaths.

- The Scottish Executive should continue to monitor 'heroin pilots' taking place in England.

- The Scottish Executive to closely monitor developments taking place outwith Scotland such as supervised consumption rooms.

2.3 Developing existing approaches

The National Investigation found that the majority of those who died of drug-related causes in Scotland in 2003 were known to at least one service, with some known to several. The victims had mainly accessed generic service providers and the services they had accessed tended to reflect local service distribution. Services were often accessed in an ad hoc, chaotic manner. Most of the victims had been discharged with inadequate follow up in place or they had failed to attend any such follow up appointments, resulting in discharge and no further action.

The action plan resulting from the Scottish Executive's Review of Drug Treatment and Rehabilitation Services (October 2004) set out a series of steps aimed at improving service quality and consistency. As part of that process, future funding to DAATs will be distributed, after negotiation, through Performance Contracts, awarded on the basis of improvements in performance against agreed targets.

Out of Hours Services

The National Investigation found that a higher proportion of methadone compared to heroin/morphine-related deaths in Scotland occurred at the weekend (defined as Friday to Sunday). The SACDM Working Group agreed that it is essential that out of hours services are developed so that those experiencing crisis outwith service providers normal working hours have access to appropriate help and support.

Retention rates and outreach

There is a strong evidence base to support the view that better outcomes are observed when people are retained in treatment. A high proportion of those who died in 2003 were not in treatment, but had had prior contact with a range of agencies before dropping out of contact. It is clear that there is potential to improve retention rates. One model would be for agencies (particularly specialist services) to follow up those with whom they have lost contact, as this group is clearly at greater risk of overdose. It would also be advantageous if the Scottish Executive were to require

DAATs to report on retention rates and on measures they have put in place to improve them.

Recommendation 6

The Scottish Executive should require DAATs and their partners to demonstrate that services are delivered in an effective and co-ordinated way with the aim of delivering clear evidence based outcomes, including improved engagement with drug users, reduction in waiting times and improvements in retention rates with services.

Suggested Points for Action

- The Scottish Executive to commission appropriate support to DAATs in order to assist them to identify the level of retention in treatment and to highlight measures that could be put in place to improve them.
- DAATs to create new ways of engaging with those drug users who are not currently using treatment services.
- DAATs to explore ways of ensuring services are available outside normal working hours and in diverse locations.
- The above recommendation to be monitored through the new performance enhanced contractual process involving DAATs and the Scottish Executive.

2.4 Targeting those at greatest risk

System to identify those at risk of overdose

The SACDM Working Group was concerned about the impact on the homeless and roofless of significant life events such as Christmas, Hogmanay, Birthdays and Anniversaries, bereavements and loss of contact with children and families. It is essential that effective linkages are made between the CAPs, local authority homelessness strategies and health and homelessness action plans, in order to ensure that the needs of problem drug users, resident in hostels/residential accommodation are effectively addressed. One means of addressing this problem would be for DAATs and Transitory Accommodation providers to develop joint systems to identify quickly those problem drug users living in hostels and transitory accommodation who are particularly vulnerable.

Co-morbidity and people with complex needs

There is increasing evidence to suggest increased rates of psychiatric disorders among those people involved in heavy drinking and drug taking. The Departments' of Health Clinical Guidelines states that approximately one-third of heavy drinkers have associated mental health problems and one-half of dependent drug takers have mental health problems of varying severity. These problems can result in poorer outcomes with greater levels of psychiatric hospitalisation and potential for overdose.

Offenders moving through the criminal justice system

The key to preventing drug deaths on release from prison is to ensure continuity of care. This is an important aspect both for treatment and integrated care. To ensure that improvements are made in this area there has to be more 'joined up' thinking in terms of continuity and standardisation of treatment practices for prisoners on entry to the prison service, as they transfer through the service, and on release back into the community. It is essential that this level of clinical intervention is needs and not resource led.

In is important that all prisoners on admission to the Scottish Prison Service (SPS), who require clinical intervention support, have access to continuity of care. Similarly, for all prisoners on liberation, who require continuity of treatment, this must be made available by the receiving DAAT's prescribing clinicians.

Services for the Homeless

The National Investigation found that at the time of death few of the study population were noted as street homeless in the fiscal files (<2%) although another 35 cases (12%) were in temporary housing at the time of their deaths.

The DAT Working Group suggested that homeless service staff and homeless people should be considered as a 'high priority' for emergency intervention training. They proposed that for staff this should improve recording of and investigation of non-fatal overdoses, rapid access to addiction services and the development of appropriate accommodation options (with support).

Services for those over thirty

The National Investigation found that drug related deaths increased at a significantly higher rate among those aged 35-54 compared to 15-24 years during 1996-2003. Those who have had a drug problem for over ten, and perhaps for as long as twenty years, are more likely to have significant health problems than those who have

a shorter history of drug use. This can put them at a higher risk of overdose than those who have used drugs for less time. The over thirties, perhaps due to their own recognition of their potential to die as a result of overdose, can be surprisingly motivated to change their behaviour.

Recommendation 7

The Scottish Executive should review services for groups where drug related deaths occur at a higher rate than the overall population of problem drug users (people recently released from prison, the homeless/roofless, people with co-morbidity and complex needs, and the over thirties) with the aim of developing services and responses that are specifically targeted at these vulnerable populations.

Suggested Points for Action

For those at greatest risk of overdose, and those complex needs i.e. co-morbidity

- DAATs and Transitory Accommodation providers to develop systems jointly that will identify quickly problem drug users in hostels and transitory accommodation who are particularly vulnerable.

- The Scottish Executive to review services for groups where drug related deaths occur at a higher rate than the overall population of problem drug users (the homeless and/or older injectors, those with complex needs i.e. co-morbidity) to ensure that services are accessible to these populations.

- Link through proposed Critical Incident Groups, e.g. identification of traumatic experiences such as having a child taken into care or suffering bereavement.

For Prisoners

- The SPS to increase the number of Addiction Nurses employed to improve the level of continuity of care and carers both within the prison and on release into the community.

- The SPS to work in partnership with DAATs to ensure that medical services, both inside and outside prison, work closely together to develop integrated care pathways which ensure that on admission to and release from prison, there is continuity of care, and where appropriate, access to substitute prescribing and supervised dispensing.

- The SPS to develop the range of clinical treatments available to prisoners, shifting the balance from detoxification to stabilisation.

- On release from prison all problem drug users to receive effective throughcare. The proposal within the new Throughcare Addiction Service arrangement, that short-term prisoners (those serving less than 31 days) cannot access addictions throughcare support, to be reviewed as a matter of urgency.

- The SPS to work in partnership with DAATs to improve the range of support services for prisoners, that are released from custody on Fridays and require support at weekends, and for those where the risk of relapse on release is thought to be very high, consideration to be given to the re-introduction of a substitute prescription prior to release.

- The SPS and the SDEA to consider formalising existing information sharing on drug related deaths in Scotland with a view to identifying trends and gaps in service provision within prisons and on release into the community.

For the Homeless

- The Scottish Executive to issue guidance to the relevant planning groups in order to ensure an appropriate response.

- DAATs to ensure sufficient capacity building support is available to transitory accommodation providers to improve responses.

- In line with the Homelessness Task Force recommendation that supported accommodation places should be made available as an alternative to hostel accommodation.

For the over thirties

- Consideration to be given on how to enhance service cover for the over thirties.

- The proposed local Critical Incidents Sub-Groups to decide how to take this action point forward.

- Existing local Critical Incident Sub-Groups to share experience for basis for terms of reference of proposed groups.

Reducing supply

The National Investigation found that benzodiazepines were the most common drugs detected in drug-related deaths. Very few cases were found to be positive for psychostimulants. The researchers noted that the widespread ingestion of benzodiazepines, in particular diazepam is a matter of great concern. The findings also suggest that illicit manufacture and/or diversion of prescribed drugs is a substantial source of drugs for users, and remains a significant issue for health service providers and others in the field.

Recommendation 8

ACPOS, DAATs and NHS Boards should consider how best to address the issue of illicit manufacture and/or diversion of prescribed drugs such as benzodiazepines and dihydrocodeine, given their prominence in the drug related deaths examined by the National Investigation.

Suggested Points for Action

- The SDEA to continue the collation of trend information and research into illegal supply of POMs, whether licitly or illicitly manufactured.
- Focus to be on:
    - Licit prescription drugs entering the illicit market via diversion from prescription;
    - Licit prescription drugs entering the illicit market at source (e.g. via Internet sales);
    - Counterfeit prescription drugs being manufactured illegally and entering the illicit market.
- DAATs and their NHS Board partners to address specific issues relating to the prescribing of benzodiazepines and opiates.
- Guidance published in the British National Formulary (BNF) and the Departments' of Health guidelines on clinical management of drug misuse and dependence to be promoted as best practice.

2.5 Service Integration, Recording and Information Sharing

Better standardised assessments

The National Investigation found that information currently collected across Scotland on the social circumstances of victims prior to their deaths was sparse, inconsistent and difficult to cross reference. This made it difficult for the Investigation Team to explore fully factors that might increase or reduce risk of drug related death. The SACDM Working Group was concerned to note that not all areas are utilising the meaningful process of Single Shared Assessment (SSA) that is described in the Effective Interventions Unit (EIU) publication, '*Integrated Care for Drug Users, Principles and Practice*' (EIU 2002).

Improved recording in clients' notes/files

The National Investigation team highlighted the need to improve the quality of clinical note keeping in order to allow closer scrutiny of the care received by victims. They found that the information contained in patients' notes was of poor quality and that most case files were held by generic services, which sometimes did not have effective methods for dealing with them.

Sharing of information

Both the National Investigation and the DAT Working Group reports highlighted the lack of uniformity across services in how drug related deaths are defined and reported. The DAT Working Group suggested that local services should develop a database containing known details and service contacts of those who died, to be used to improve risk assessment and inform service improvements that avoid breakdowns in care pathways.

The National Investigation found that most people suffering drug related deaths were known to services and many were accessing more than one of these at the same time. The services were often generic (i.e. not specialists in the field of substance misuse) and were often accessed in an ad hoc, chaotic manner. Most people were discharged with inadequate follow up in place or they failed to attend any such follow up appointments resulting in their discharge from the service and no further action being taken.

Recommendation 9

Priority must be given to greater development of the Single Shared Assessment as highlighted by the EIU in *'Integrated Care for Drug Users, Principles and Practice'*; improving and standardising clinical note taking; and developing effective methods for dealing with clients' case files across Scotland. To support these efforts, it is essential that robust systems for sharing of information between local generic, specific and voluntary services are developed as a matter of urgency.

Suggested Points for Action

For Single Shared Assessment

- The Scottish Executive to reinforce the importance of services using Single Shared Assessments (SSAs).
- EIU work on SSAs to be developed further with the aim of setting standards and a time frame for the roll-out of a simple to use SSA process for all substance misusers in Scotland.
- Local areas to introduce the use of SSA as a priority and ensure that all staff are trained in their use.

To improve recording in clients' notes/files

- Priority to be given to improving and standardising clinical note taking and effective methods for dealing with case files.
- DAATs to ensure, through their health, social work and voluntary sector partners, the standardisation of information collected by all services which are commissioned in their area (in line with Joint Futures, SSAs and Integrated Care).
- A database of details and service contacts of those who died to be maintained and used to improve risk assessment and inform services in order to avoid breakdowns in care pathways.

For information sharing

- DAATs and their partners to encourage service users to agree to the introduction of systems that will allow the sharing of relevant information about them between services in order to improve their safety.

- The prevalence intervention developed by the three Grampian DAATs should be used as a model of good practice across Scotland

2.6 Training for service professionals, staff and the voluntary sector

Both the National Investigation and the DAT Working Group reports mentioned the importance of staff training as a means of reducing drug related deaths. In addition, the National Investigation found that only a minority of those who died had accessed medical interventions prior to their death. When medical care was accessed the intervention provided was often the prescription of methadone. The quality of methadone prescribing was often outside that contained in the national prescribing guidance (Departments' of Health 1999).

Recommendation 10

The NHS in Scotland and relevant partners (e.g. Royal Colleges and academic institutions) should consider supporting the development of a national process to promote good practice in the delivery of medical treatment to drug misusers. This should include availability of a comprehensive range of accredited training (Scottish Training on Drugs and Alcohol (STRADA)), The Royal College of General Practitioners (RCGP); and the development of meaningful prescribing guidance, such as a (Scottish Intercollegiate Guidelines Network (SIGN) guideline); and the creation of clinical governance (managed care) networks.

Suggested Points for Action

- Access to validated training in relation to the management of substance misuse in primary care must be made freely available to all Scottish GPs, pharmacists and nurses working in the field of substance misuse, this to include agreed local standards and clinical audit, overseen by local clinical governance processes.

Health Care Practitioners Working within the Scottish Prison Service

The University of Nottingham has been running a Diploma in Prison Medicine since the late 1990s. The course is accredited by the Royal Colleges of Physicians, General Practitioners and Psychiatrists Examinations Steering Committee. In late 2004 the RCGP announced the launch of a universal programme in prison medicine.

The RCGP is linking with the University of Lincoln to convert the RCGP Diploma in Prison Medicine into a multidisciplinary Masters programme. Recently the Scottish Executive made funding available for 60 GPs, 20 pharmacists and 20 nurses in Scotland to undertake Part 2 of the RCGP Certificate in the Management of Drug Misuse in Primary Care. It would be helpful if SPS Prison Medical Officers had the opportunity to undertake the courses in prison medicine and drug misuse.

Critical Incident and Resuscitation Awareness within Prisons

The National Investigation suggested that there is a need to ensure that all opportunities are taken to intervene when drug users are in prison. As well as improving access to treatment within the prison environment, it is also essential that prison staff are competent to deal with drug related incidents that occur in the prison setting.

Recommendation 11

Resources should be made available to allow prison medical and nursing staff to undertake the RCGP Certificates in the Management of Drug Misuse in Primary Care and the Universities of Nottingham and Lincoln Prison Medicine programmes. In addition, the Scottish Prison Service in conjunction with the Scottish Drugs Forum should adapt critical incident resuscitation awareness training for use within the prison setting.

Suggested Points for Action

- SPS to establish links with relevant external organisations to promote the development of resuscitation awareness training for staff and prisoners.

- SPS to develop substance misuse information, using a range of media, for prisoners on admission, during sentence and pre-release. This to include the dangers to reduced tolerance to drugs and alcohol, injecting, inhalation and oral use of drugs.

Raising awareness and Improving co-ordination

The National Investigation noted that there is a need to increase awareness of those in contact with drug misusers as most of those who died were known to services and many were accessing more than one service at the time of their death.

Recommendation 12

Training aimed at raising awareness and improving co-ordination of activity for those generic staff most likely to come into contact with people vulnerable to overdose should be provided as a matter of urgency.

Suggested Points for Action

- Training of generic staff to be reviewed with a view to establishing a standard for training that is aimed at raising their awareness of drug related deaths and improving activity to reduce prevalence in all relevant disciplines.

2.7 Planning and co-ordination of response

Local Planning

The DAT Working Group found that whilst it is evident that all DAATs have in some way considered the issue of how to reduce drug related deaths, the actual development of detailed local strategies (e.g. Critical Incidents Groups or similar mechanisms) has been less widespread. Valuable examples of developments in several areas are given in the report. In particular the Ayrshire and Arran model is a good working example that other areas might wish to adopt in the establishment of similar working groups.

Recommendation 13

Under the auspices of the Drug and Alcohol Action Teams each area should establish a local standing drug deaths monitoring and prevention group that involves key agencies in order to manage rapid sharing of information on near misses, deaths and street drug trends, to instigate action and report on progress in implementing proposals to reduce deaths.

Suggested Points for Action

- The Scottish Executive will require each DAAT to establish a local standing drug deaths monitoring and prevention group, which has representation from Accident and Emergency (A&E), DAAT drug co-ordinator, local police drug co-ordinator, Fiscal's office etc.

- A significant event and/or critical incident review should be undertaken locally following every drug related death,

whether the death occurs in primary or specialist care. The review should aim to include all professionals who are involved in the care of the patient.

- Improved liaison between agencies to be assisted by maintenance of database that contains details and service contacts on those who died.

- The Ayrshire and Arran Alcohol and Drug Team's Death Review Group to be used as an example of good practice.

2.8 Monitoring Drug Related Deaths

Both the *"Scottish Confidential Inquiry into Methadone Related Deaths of 2001 (Scott, Jay et al 1999)"* and the National Investigation comprehensively and systematically examined the circumstances of death of those dying of drug related causes during the relevant periods of investigation. Both provided valuable information on the causes of death and have highlighted areas for improvement in services.

The National Investigation and its analysis demonstrated important differences between victims of drug related deaths in Scotland when compared to London. One key question posed by the investigators is, "to what extent the differences follow and are due to, the underlying trends and patterns of drug use in Scotland?" Or, "are there differences in the availability and delivery of treatment, and investigation of drug related deaths, that may have a bearing on mortality statistics and mortality rate in Scotland?" The investigators proposed that other studies would be required to test potential explanations and hypotheses for these differences.

Definition of drug related death

The National Investigation found that the definition of a 'drug related death' is not straightforward. It advised that a useful discussion on the definition or the definitional problems may be found in an article in the Office for National Statistics (ONS) publication '*Population Trends*'. In its 2000 report, '*Reducing Drug Related Deaths'* (ACMD 2000), the ACMD considered current systems used in the United Kingdom to collect and analyse data on drug related deaths. The ACMD recommended that a 'short life technical working group should be brought together to reach agreement on a consistent coding framework to be used in future across England, Wales, Scotland and Northern Ireland'. General Register Office for Scotland (GROS) was represented on the resultant group.

The ONS 'standard' definition essentially relates to deaths related to drug poisoning. It looks at the underlying cause of death according to the International Classification of Diseases (ICD) criteria. It is the broadest of the official definitions, covering anything from heroin to aspirin to volatile substances.

The UK Drug Strategy definition is somewhat narrower, e.g. excluding non-opioid analgesics. This definition looks at both the underlying cause in terms of ICD codes and the status of the drug i.e. controlled under the Misuse of Drugs Act 1971.

Both ONS and GROS now use this UK Drug Strategy definition as their main definition on official publications on drug related death statistics.

It is important to ensure that whoever is collecting the data has as broad a definition as possible so that all three requirements, plus any others which are needed at a national (e.g. Scottish) or regional or local level can be catered for. This enables ONS, GROS and the National Programme on Substance Abuse Deaths (np-SAD) to provide data on a range of sub-samples.

The National Investigation presented its information on drug related deaths using this approach. Further details of that can be found in Appendix 1 of the National Investigation's report (Substance Misuse Research 2005).

Recommendation 14

The definition of a drug related death must be standardised nationwide with the same definition being used by all involved in its investigation. For instance, a drug related death could be defined as any death, at any age group, that is directly or indirectly related to the use of controlled substances. This would include accidental, suicidal, homicidal deaths, including those in the very young and in older age groups and excludes deaths from overdoses of other medicinal drugs. This definition would trawl all deaths from benzodiazepines.

Suggested Points for Action

- UK Drug Strategy definition of drug related death to be widely disseminated and used throughout Scotland.

Establishment of National Confidential Inquiry

In its report the DAT Working Group proposed that a national steering group should be developed with a remit to look at how

recommendations from the ACMD *'Reducing Drug Related Deaths'* report and the findings of the National Investigation could best be implemented across Scotland.

Members of the SACDM Working Group were very impressed by the "Confidential Inquiry" process and were strongly of the opinion that such a process should be used routinely for the investigation of drug related deaths in Scotland. Experience gained from the National Investigation, the Glasgow Confidential Inquiry into Methadone Related Deaths of 1996, the Scottish Confidential Inquiry of 2001, and the np-SAD, based at St George's Hospital, London, could all be used as examples of good practice.

We propose that consideration should be given to the introduction of an ongoing National Confidential Inquiry into Drug Related Deaths in Scotland.

Recommendation 15

A National 'Preventing Drug Related Deaths Forum' should be established with a remit to report to Ministers annually on trends and causes of drug related deaths in Scotland.

Suggested Points for Action

- As a priority the Scottish Executive, through the SACDM 'Preventing Drug Related Deaths Forum', should develop a minimum data set to be collected in all cases of drug related death in Scotland. This dataset to be comprehensive and in line with other UK and European monitoring systems (e.g. the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)).

- The Scottish Executive to establish a National Confidential Inquiry into Drug Related Deaths under the auspices of the proposed 'Preventing Drug Related Deaths Forum'.

- The National Confidential Inquiry to collate drug related death data and perform detailed comparisons of trends to increase availability of valuable information on local and national indicators of risk factors.

- Experience gained from the National Investigation, the 1996 Glasgow Confidential Inquiry into Methadone Related Deaths; the 2001 Scottish Confidential Inquiry; and np-SAD all to be used as examples of good practice.

2.9 Toxicological findings and circumstances of death

Interpretation of Toxicology

The National Investigation's researchers found that the mean blood morphine and methadone concentrations recorded in most cases of drug related death were significantly lower in Scotland compared to London. The Researchers suggested that it was unclear whether this factor reflects a true difference in consumption patterns and prescription dosage, or differences in the toxicological testing between sites. Mean alcohol concentration was higher in the Scottish sample, but this finding did not explain any difference in the mean heroin concentration between Scotland and London.

Recommendation 16

In order to enable a long term, meaningful interpretation of post-mortem toxicological data, Procurators Fiscal, who instruct autopsies on these deaths, should insist that the pathologists carrying out the autopsies follow a nationally agreed protocol based on an agreed best practice model.

Suggested points for action

- A nationally agreed protocol based on an agreed good practice model to be developed and disseminated to pathologists who carry out drug related deaths autopsies.

References

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Department of Health, The Scottish Office Department of Health, Welsh Office and DHSSNI (1999) Drug Misuse and Dependence – Guidelines on Clinical Management. The Stationary Office, London ISBN 0 11 322277 7

EIU (2002) Integrated Care for Drug users, Principles and Practice. Scottish Executive, Edinburgh.

Scottish Executive, Drug Treatment and Rehabilitation Review (2004),
http://www.scotland.gov.uk/library5/health/drugrehabreview.pdf

Substance Misuse Research (2005) National Investigation into Drug Related Deaths in Scotland, 2003.

WHO Model List of Essential Medicines
http://www.who.int/medicines/

Appendix A

Membership of SACDM Drug Related Deaths Working Group

Kay Roberts (Chair)	SACDM and Co-ordinator of the Greater Glasgow Needle Exchange Scheme (until end July 05)
Professor Anthony Busuttil	Regius Professor of Forensic Medicine, University of Edinburgh Medical School
Dr Brian Kidd	Clinical Senior Lecturer in Addiction Psychiatry, Centre for Addiction Research & Education, Scotland, University of Dundee
David Liddle	Director, Scottish Drugs Forum
Graham Jackson	Statistician, General Register Office for Scotland
Jane Jay	Specialist in Addictions, NHS Lothian
Andrew Marsden	Scottish Ambulance Service
Mike McCarron	National Officer, The Association of Drug Action Teams in Scotland
Karen Norrie	Addictions Advisor, Scottish Prison Service
Samantha Perry	Accident and Emergency, Greater Glasgow NHS Board
Dr Bill Reith	General Practitioner, Aberdeen
Professor Richard Simpson	Consultant Psychiatrist (Addictions) Lothian NHS
David Spiers	Procurator Fiscal, Airdrie
Gillian Wood	National Drug Co-ordinator, Scottish Drug Enforcement Agency
Tom Wood	Chair, Action on Alcohol and Drugs in Edinburgh
Deborah Zador	Consultant in Addictions, Forth Valley Community Alcohol and Drugs Service (until July 05)
Secretariat:	
Sandra Wallace	Scottish Executive
Stella Fulton	Scottish Executive

Appendix B

National Investigation into Drug Related Deaths, 2003

Chapter 7: Conclusions and Implications

What is in this chapter? This chapter reviews the findings from individual chapters and draws together a final set of conclusions along with associated implications for service commissioners and providers.

Where did the information come from? The information has been drawn from the "key points" sections from each chapter in the body of the report

Introduction

This investigation has comprehensively examined the circumstances of death, social circumstances and service contacts of those dying as a result of a drug-related death in Scotland in 2003. It has also considered long-term trends in drug-related death in Scotland and has compared the circumstances of the 2003 Scottish deaths with data from a concurrent study into drug-related deaths in London for the same year. Finally the investigation has compared service utilisation characteristics of a group of living injecting drug users with a sub-sample of deaths drawn from the same geographical area and has explored the opinions, beliefs and knowledge of living injectors regarding overdose risk.

The developing evidence-base implies that many drug-related deaths may be preventable and this investigation aimed to identify areas which, if effectively addressed would impact on the rate of drug-related deaths in Scotland.

Each chapter of the report has therefore identified "Key Points" based on the data collected. These are summarised below and, with the exception of chapter 2, have been used to generate implications for service commissioners and providers arising from the findings of this investigation.

Describing the study population and trends over time

Most Scottish drug related deaths in 2003 were male, in their early 30s (mean age of 32.8 years), living at home in a house or flat, often with others, and were long-term or dependent drug users. These findings indicate that very few cases were homeless single drug users. Most were considered to have been accidental drug overdoses (based on ICD-10 criteria for drug related deaths), although a sizeable 13% were classified as suicides. These characteristics are consistent with previous published studies into drug related deaths.

Trends in drug-related deaths in Scotland from 1996 to 2003 were complex and showed a great deal of heterogeneity over time in relation to geographical distribution and the involvement of heroin/morphine or methadone. Drug-related

deaths involving heroin/morphine had increased at a significantly higher rate than those involving methadone in Scotland during 1996-2003 (13.8% vs –0.4% per year, respectively). In Glasgow, however, deaths involving heroin (which increased at an average 6.5% per year) increased at a higher rate than those involving methadone (increasing with an average rate of 9.7% per year).

Drug-related deaths involving heroin/morphine had increased at a significantly higher rate out-with the main urban centres of Glasgow and Lothian during 1996-2003, and likely relates to the growth of drug use in these areas. Overall, there were twice as many deaths involving heroin/morphine as methadone. However, the ratio of heroin/morphine : methadone overdose deaths varied considerably between geographical areas – for example, from 117 : 26 in Lanarkshire to 21 : 70 in Tayside and 59 : 175 in Lothian. These differences should be investigated further.

A higher proportion of methadone compared to heroin/morphine–related deaths in Scotland occurred at the weekend (defined as Friday to Sunday) and may be associated with non-supervised prescribing of methadone at the weekend.

The finding that drug-related deaths in Scotland, including those involving either heroin/morphine or methadone, have increased at a significantly higher rate among those aged 35-54 compared to 15-24 years during 1996-2003 could be attributed to an ageing population of drug users.

Toxicological findings and circumstances of death

1. There were missed opportunities to intervene and save the lives of many of the people who died. Less than half had tried CPR and most cases had died by the time the ambulance arrived.

Implications

There is a need to develop and deliver training and education for drug users and their families to increase awareness of the risks of overdose, how to avoid it, how to identify it and how to respond effectively.

2. Benzodiazepines were the most common drugs detected in drug-related deaths. Few cases were positive for psychostimulants, in particular cocaine. The predominant drugs found at the time of death continue to be heroin/morphine, benzodiazepines and alcohol in Scotland. There was a high proportion of cases who did not inject any drugs nor use heroin prior to overdose and death. Drug users who do not inject heroin are also at risk of fatal drug overdose. Diversion of prescribed drugs is a significant problem with nearly half of methadone related deaths, and two-thirds of diazepam and dihydrocodeine positive deaths involving illicitly obtained medications.

Implications

There is a need to address prescribing practices in relation to the drugs implicated in these deaths – benzodiazepines and oral opiates – much of which is likely to be emanating from General Practice. This could be considered under the quality agenda within the GP contract.

Services must be aware of the risks of non-injecting drug use and must continue to warn drug users and the broader community of the dangers of combinations of drug use including alcohol. Drug treatment services may also need to be aware that

non-injecting dependent drug (in particular licit drug) and alcohol users, especially older users, may not be attracted into seeking help from them because they may not identify with their younger, illicit drug using injecting clientele.

3. The same drug-related cause of death may be recorded on the death certificate by forensic authorities in various ways.

Implications

Introducing a standardised, uniform nomenclature for recording drug-related deaths on medical certificates would improve the monitoring and researching of drug-related deaths. Systematic collation and availability of forensic toxicological data would also assist the monitoring and analysis of drug use trends in fatalities.

4. London drug related deaths showed broadly similar demographic and circumstantial characteristics to those of Scottish deaths but significantly differed on toxicological findings – London deaths had a higher proportion of cases positive for cocaine, and a lower proportion positive for benzodiazepines and dihydrocodeine. Blood drug concentrations also significantly differed with higher morphine and methadone levels among the London group and a higher blood alcohol concentration in the Scottish group.

Implications

Differences in toxicological characteristics between the two groups raise questions about possible differences in prescribing practices of benzodiazepines, dihydrocodeine and methadone across London and Scotland, and suggest differences in heroin purity and cocaine use between the two regions.

Social circumstances prior to death

1. Information, as it is currently collected across Scotland is sparse, inconsistent and difficult to cross-reference.

Implications

Use of a standardised, well-validated method of collecting agreed data on all drug deaths would substantially facilitate the identification of relevant social risk factors.

2. The lack of up to date relevant information in many of the casefiles, which would be required to organise an integrated care plan is a concern. The availability of rich, up to date information would allow identification and prioritisation of potential risk factors in this vulnerable population which could reduce future morbidity and mortality and must form part of good practice in the management of drug misusers.

Implications

Staff in all settings should be trained to comprehensively and holistically assess drug misusers and to ensure that regular updates of essential information (eg regarding childcare responsibilities, life events etc.) are recorded. Nationally, standards could be set within the DAT Corporate Action Plan requiring recording of adequate information. Locally, DATs and their health and Local Authority partners could ensure that services are commissioned with clear quality standards and monitoring procedures in place.

Contact with services

1. Most people who died of drug-related causes were known to services and many were accessing more than one. These services were often generic (i.e. not specialists in the field of substance misuse) and were often accessed in an ad hoc, chaotic manner. Following this contact, most were discharged with inadequate follow up in place or failed to attend any such follow up appointments resulting in discharge and no further action.

Implications

There is a need to increase awareness of this problem and to deliver training and improved coordination of activity for those generic staff most likely to come into contact with this group – General Practitioners, Psychiatric services, Accident & Emergency and Social Work.

2. Medical interventions were only accessed by a minority. When accessed the intervention was often prescribed methadone. Quality of methadone prescribing was often outside that contained in national practice guidelines. Few of those prescribed methadone were in receipt of any counselling.

Implications

Methadone replacement should be prescribed only in line with the current evidence base – following a full assessment of drug problems and dependency; in adequate doses to meet need; dispensed safely and effectively under supervision until the person is demonstrably stable. Methadone replacement prescribing should be delivered alongside supportive counselling.

3. Seventy had been in prison in the last 6 months. Transitional Care is not being made available to all who require it. Prisons show varying success regarding take-up rates. Ten people died within 3 days of release of which 6 were released on a Friday.

Implications

There is a need to ensure all opportunities are taken to intervene when drug misusers are in prison. In particular, there is a need to ensure that effective communication takes place so that imprisonment does not interrupt treatment (if in treatment before incarceration) or (if not in treatment) that the time in prison gives an opportunity to increase access to treatment and reduce risk of overdose.

Interviews with overdose survivors

The majority of overdoses occurred amongst those who had taken more than one substance on the day of overdose. Heroin had been taken in all but one overdose. Heroin and diazepam taken together or on the same day was the most common combination, taken in 22 cases. In fifteen overdoses heroin and diazepam were the only drugs consumed; in the remaining five episodes they were taken in combination with one or two other substances and/or alcohol.

Injecting drug users are aware, to some extent, of the overdose risks, although this knowledge is not extensive. Less than half mentioned tolerance as a factor and less than half considered that a mixture of drugs could be risky. There were some misconceptions about overdose risk factors. Some injecting drug users believed that overdose would not occur if heroin was smoked or if it was injected by itself. Injecting with someone else present was the most frequently cited prevention strategy.

Inflicting physical pain was the most common intervention used by injecting drug users. Although putting the overdose victim into the recovery position was cited by half the sample, the infliction of pain was still regarded as the most effective strategy. Half of the sample was worried about having another overdose. Among those who were not worried, some claimed not to care whether they lived or died.

Implications

There is a need to develop and deliver training and education for drug users and their families to increase awareness of the risks of overdose, how to avoid it, how to identify it and how to respond.

Conclusion

This investigation has identified a number of implications for services in the prevention of future drug-related deaths in Scotland. It has highlighted some limitations of fiscal and national registry office data on drug-related mortality and has raised aspects of drug-related deaths requiring further research. Finally, the report provides some baseline indicators by which the potential effectiveness of interventions to prevent or reduce drug related deaths in future might be measured. Some of these outcome measures might include improved after care from prison, improved delivery of methadone treatment, and increased engagement of drug users with services especially drug treatment services.

Appendix C

Report of the Association of Drug Action Teams: Drug-Related Deaths Working Group

Section 5

Recommendations

Action Team and Local Services Recommendations:

Development of Local Action Team Critical Incidents Groups: Continued improvement in liaison between agencies over drug deaths, e.g. setting up a standing drug deaths monitoring and prevention group, involving key agencies to ensure rapid sharing of information on deaths/street drug trends, and to report on progress in implementing proposals to reduce deaths.

Database development: Local services should develop a database containing known details and service contacts of those who died, to be used to improve risk assessment and inform service improvements that avoid breakdowns in care pathways.

Linkages with Accident & Emergency: All Action Teams should consider the experience of the three Grampian Action Teams and review their current relationship with Accident & Emergency Departments.

Improving Witness / Emergency Intervention: All Action Teams should consider as a priority ways of decreasing delays at the scene of an overdose, and methods for raising the level of resuscitation skills among drug users, family members, service providers and social networks.

Key to this recommendation is the expanded delivery of local First Aid training, with a particular focus on dealing with overdose. Efforts should be directed towards peer education, emergency services, and family support groups. Action Teams should therefore identify local structures and resources required for advancing training that utilises both peer and social support networks. A valuable resource for Action Teams in advancing this area will be the new SDF initiative.

Homelessness services staff and homeless people should be considered as high priority for emergency intervention training. For staff this should include improved recording and investigation of non-fatal overdoses, rapid access to addiction services, and development of appropriate accommodation options (with support).

Best Practice in the use of Naloxone: Local Critical Incidents Groups or other similar structures should consider the benefits, particularly within 'hot spots', of the extended use of Naloxone.

Staff Training: A resource pack (including 'Know The Score' materials and wider training presentations) should be developed to assist local addiction managers in familiarising staff with good overdose prevention practice. Such training should form

part of a rolling programme. Coupled with this, steps should be taken to emphasise overdose prevention training as part of local training strategies.

Association of Drug Action Teams Recommendations:

Amendment to the Medicines Act:

The Association of Drug Action Teams should consider recommending an amendment to the use of the Medicines Act that would place Naloxone on the 'safe' list for general administration. Such a change would create the opportunity, for those areas that wish to do so, to proceed with local fatal overdose prevention pilots to include the use of Naloxone.

National Strategy, Co-ordination and Communications:

National "Preventing Drug-Related Deaths" Forum:

A national steering group to be developed, with a remit to look at how recommendations from the ACMD 'Reducing Drug-Related Deaths' report and findings of National Investigation can be best implemented across Scotland. Representation should include police, prison, Scottish Ambulance Service, Accident & Emergency departments, Action Teams, and relevant service sectors. This group should look at wider initiatives such as safer injecting rooms and heroin prescription, and how such initiatives might reduce drug-related deaths.

National Communications / "Know The Score":

It is recommended that an updated overdose related publication of 'Know The Score' is published and addresses the issue of 'scene of crime' versus 'medical emergency'.

National Conference

Members recommend that during 2005 a multi-disciplinary conference on reducing drug-related deaths be hosted by the Scottish Executive. Such an event should draw on the experiences of this working group together with the findings from the national investigation.

Appendix D

List of Recommendations

1. The Scottish Executive and DAATs should consider methods to raise the level of resuscitation skills among drug users, family members, friends, and social networks. It is recommended that the provision of information and training for families and friends of drug users and drug users themselves is further developed across Scotland.

2. ACPOS and the Scottish Executive should jointly explore ways in which contact with the police can be used as an opportunity to intervene with vulnerable individuals in order to prevent future drug related deaths. In particular, the MOU between ACPOS and the Scottish Ambulance Service should be reviewed in order to ensure that, in the event of an overdose, help is available as quickly as possible. The police attending the scene of an overdose should ensure that preservation of life should take precedence.

3. The Scottish Executive should commission applied research to explore drug user perceptions, and those of their friends/family, with a view to understanding how delays in contacting the emergency services can be reduced.

4. NHS Boards and their primary care management components should be encouraged to employ the nGMS and nGPS frameworks to increase access to high quality, evidence based treatment programmes for substance misusers.

5. The Scottish Executive should develop and fund a co-ordinated process of introduction and evaluation of new or more innovative treatments across Scotland, with the aim of ensuring that substance misusers in all DAAT areas have access to a range of evidence based treatments.

6. The Scottish Executive should require DAATs and their partners to demonstrate that services are delivered in an effective and co-ordinated way with the aim of delivering clear evidence based outcomes, including improved engagement with drug users, reduction in waiting times and improvements in retention rates with services.

7. The Scottish Executive should review services for groups where drug related deaths occur at a higher rate than the overall population of problem drug users (people recently released from prison, the homeless/roofless, people with co-morbidity and

complex needs, and the over thirties) with the aim of developing services and responses that are specifically targeted at these vulnerable populations.

8. ACPOS, DAATs and NHS Boards should consider how best to address the issue of illicit manufacture and/or diversion of prescribed drugs such as benzodiazepines and dihydrocodeine, given their prominence in the drug related deaths examined by the National Investigation.

9. Priority must be given to greater development of the Single Shared Assessment (SSA) as highlighted by the EIU in '*Integrated Care for Drug Users, Principles and Practice'*; improving and standardising clinical note taking; and developing effective methods for dealing with clients' case files across Scotland. To support these efforts, it is essential that robust systems for sharing of information between local generic, specific and voluntary services are developed as a matter of urgency.

10. The NHS in Scotland and relevant partners (e.g. Royal Colleges and academic institutions) should consider supporting the development of a national process to promote good practice in the delivery of medical treatment to drug misusers. This should include availability of a comprehensive range of accredited training (Scottish Training on Drugs and Alcohol (STRADA)), The Royal College of General Practitioners (RCGP); and the development of meaningful prescribing guidance, such as a (Scottish Intercollegiate Guidelines Network (SIGN) guideline); and the creation of clinical governance (managed care) networks.

11. Resources should be made available to allow prison medical and nursing staff to undertake the RCGP Certificates in the Management of Drug Misuse in Primary Care and the Universities of Nottingham and Lincoln Prison Medicine programmes. In addition, the SPS in conjunction with the SDF should adapt critical incident resuscitation awareness training for use within the prison setting.

12. Training aimed at raising awareness and improving co-ordination of activity for those generic staff most likely to come into contact with people vulnerable to overdose should be provided as a matter of urgency.

13. Under the auspices of the DAATs each area should establish a local standing drug deaths monitoring and prevention group that involves key agencies in order to manage rapid sharing of information on near misses, deaths and street drug trends, to

instigate action and report on progress in implementing proposals to reduce deaths.

14. The definition of a drug related death must be standardised nationwide with the same definition being used by all involved in its investigation. For instance, a drug related death could be defined as any death, at any age group, that is directly or indirectly related to the use of controlled substances. This would include accidental, suicidal, homicidal deaths, including those in the very young and in older age groups and excludes deaths from overdoses of other medicinal drugs. This definition would trawl all deaths from benzodiazepines.

15. A National 'Preventing Drug Related Deaths Forum' should be established with a remit to report to Ministers annually on trends and causes of drug related deaths in Scotland.

16. In order to enable a long term, meaningful interpretation of post-mortem toxicological data, Procurators Fiscal, who instruct autopsies on these deaths, should insist that the pathologists carrying out the autopsies follow a nationally agreed protocol based on an agreed best practice model.

Appendix E

Glossary of Terms

ACMD	Advisory Council on the Misuse of Drugs
ACPOS	Association of Chief Police Officers in Scotland
A&E	Accident and Emergency Departments of hospitals
Autopsy	(post-mortem examination) – a comprehensive investigation of the body of a deceased person, carried out by a pathologist. It includes and external and internal examination of all body systems as well as the taking of specimens for a laboratory analysis
Benzodiazepines	Tranquillisers (depressants) e.g. diazepam, temazepam or nitrazepam
BNF	British National Formulary
CAP	Corporate Action Plan
Case Files/Notes	Comprehensive dossier maintained for each individual patient/client, which contains all the written documents relating to the care of a patient/client, including the results of specialised investigations and any tests that have been carried out. Family doctors and hospital doctors keep a file of each patient separately, other agencies, such as social work and drugs services, also maintain separate files.
CD	Controlled Drugs

Co-morbidity	Co-existence of mental illness, drug and/or alcohol misuse.
Confidential Inquiry	An anonymous general; scrutiny by a multidisciplinary panel of medical and other experts of the clinical and autopsy documents relating to a death with the scope of; a) discovering if the death was preventable; b) if changes in care are required; and c) if changes in the manner of investigation of the death are required. Confidential Inquiries publish annual reports.
CPR	Cardio-pulmonary Resuscitation
DAAT	Drug and Alcohol Action Team
DAT Working Group	Association of Drug and Alcohol Action Teams' Short-life Information Sharing Sub-group
Departments' of Health	Health Departments in Scotland, England, Wales and Northern Ireland
EIU	Effective Interventions Unit
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction – collects, analyses and disseminates objective, reliable and comparable information on drugs and drug addiction in the European Union.
Generic Services	Non-specialist services e.g. General Practice, Community Pharmacy.
Generic Staff	GPs, pharmacists, Accident and Emergency staff, Social Work staff, *Acute* Psychiatric Services

GP	General Practitioner
GROS	General Register Office for Scotland
ICD	International Classification of Diseases
IDU(s)	Intravenous Drug Users(s)
Integrated Care Pathways	Combines and co-ordinates all the services required to meet the assessed needs of the individual.
MO	Medical Officer
MOU	Memorandum of Understanding
nGMS	NHS General Medical Services Contract
nGPS	NHS General Pharmaceutical Services Contract
NHS Board	Organisation responsible for the strategic planning of health services and measures to improve the health of the community in their region.
np-SAD	National Programme on Substance Abuse Deaths
ONS	Office for National Statistics
Psychostimulants	Stimulant drugs (uppers) e.g. cocaine or amphetamine
POM	Prescription Only Medicine
Primary Care Practitioner	General Practitioner, Practice Nurse, Community Pharmacist
Royal Colleges	Royal College of Psychiatrists, Royal College of Physicians, Royal College of General Practitioners,

	Royal Pharmaceutical Society of GB, Royal College of Nursing etc.
SACDM	Scottish Advisory Committee on Drug Misuse
SDEA	Scottish Drugs Enforcement Agency
SDF	Scottish Drugs Forum
SCS	Shared Care Scheme
SIGN	Scottish Intercollegiate Guidelines Network. SIGN is an independent body that publishes guidelines which are subject to regular revisions. The Guidelines are developed after wide consultation with specific experts from the Royal Colleges in Scotland together with other experts in the field with the scope of listing evidence based best practice guidelines to assist those treatment particular conditions.
SMR	Substance Misuse Research
SMR 24/SMR 25	Forms used to record data for the Scottish Drug Misuse Database
Specialist Services	Dedicated drug services
SPS	Scottish Prison Service
SSA	Single Shared Assessment – aims to create a single point of entry to community care services with a view to better use of resources and more effective outcomes for people in need.

STRADA	Scottish Training on Drugs and Alcohol: aims to improve the skills of professional staff who address drug and alcohol misuse.
Subutex®	Brand name for Buprenorphine
WHO	World Health Organisation

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